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ABSTRACT

Evidence indicates that a significant number of medical students have pervasive communication problems that affect their interaction with patients, faculty, clinical associates, and hospital staff. This paper describes the dynamics of the communication syndrome (clinically identified as "reticence"), discusses the manifestations and implications of reticence for medical professionals, and outlines a comprehensive communication skills program designed for first-year medical students. Reticence, defined as the avoidance of social, verbal interactions or repeated ineffectiveness in communication encounters, is discussed according to eleven characteristics. The paper describes a pilot reticence program for first-year medical students which assumes the need for a physician to establish interpersonal relationships and follows a modified goal analysis format. The paper concludes that in spite of the program's one-year existence results are encouraging in that participants showed increased confidence interacting with faculty members in a video-taped diagnostic interview program. (MAI)

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Physician Reticence: Detection and Treatment

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In the social, academic, and professional arenas, verbal communication is a primary mode of human interaction and emotion and personality expression. Given the growing number of medical malpractice suits (1-3) and the public's increasing dissatisfaction with the impersonalness and perfunctoriness characteristic of many doctor/patient interactions (4-5), the development of effective interpersonal skills is essential to those entering the medical profession. However, evidence indicates that a significant number of medical students have pervasive communication problems affecting the nature of their interactions with patients as well as faculty, clinical associates, hospital staff, peers, etc.

Working with first year medical students at Southern Illinois University-Carbondale, in the context of an interpersonal skills class and a videotaped diagnostic interviewing program, over 15% of the students involved expressed concerns or displayed signs of a communication syndrome clinically identified as Reticence (6-10). In light of the above findings, this paper aims to 1) describe the dynamics of the communication syndrome, Reticence, 2) describe the manifestations and implications of Reticence for medical professionals, 3) suggest a comprehensive program for the detection and treatment of Reticent medical students.

Dynamics of Reticence

All of us, at one time or another, are uneasy in certain types of interpersonal situations or interactions and thus may tend to dread and/or avoid such events. However, when this uneasiness is either pervasive, affecting many areas of one's life, or affecting those areas most significant to

one's personal and professional goals, then the person can be said to have a communication problem. That is, if we look at verbal communication as a means of accomplishing certain goals, a person has a communication disability if his/her present communication behaviors are ineffective, thwarting goal achievement.

Specific definitions of Reticence include: avoidance of social, verbal interactions; unwillingness or pervasive uneasiness in entering into communication situations unless prodded; repeated ineffectiveness in communication encounters. A Reticent person's perceptions of what can be gained through participation with others is often outweighed by uncomfortableness or anxiety and consequent perceptions of projected losses, so nonparticipation or minimal obligatory participation becomes a defense weapon.

Some general traits and perceptions characteristic of Reticence include:

1. a unidirectional and egocentric perception of interpersonal communication. Characteristic of Reticence is the feeling that others are "judging" you (i.e., your behaviors, appearance, beliefs, abilities) and consequently Reticent communicators create unrealistic expectations of self and distorted interpretations of others' motives and perceptions. Conversely, Reticence includes a lack of awareness of the effects of one's behaviors on others. Thus Reticent communicators have difficulty accurately interpreting others' cues and using them as guides to effectively monitor their own behavior.

2. difficulty initiating conversations, particularly unstructured, non-goal specific conversations with others. A Reticent person might assume a passive role waiting for others to initiate the conversation

and then respond succinctly, avoiding unnecessary elaboration. Often the assumption is made that if the other person does not take the initiative, then that person is not interested in interaction.

3. a "negative self-concept." Characteristically, Reticent communicators perceive themselves as "inferior," or "unimportant," or "undeserving," or "lacking" in some respect. They perceive others as more confident than they and sometimes rationalize that their own accomplishments are inconsequential or inferior as compared to those of others.

4. a fear and avoidance of asking questions in a formal or classroom context and a fear and avoidance of interactions with "authority figures." A Reticent person may feel "foolish" and "the center of attention" when asking questions in class and so tends to avoid doing so. There is also a tendency to feel "uneasy," "inferior," "judged" and at a loss for anything "important" to say when interacting with authority figures (e.g., faculty, administrators, etc.) and so a Reticent communicator avoids engaging in any extraneous, unnecessary conversation with such figures.

5. a fear of any public speaking situations. Frequently expressed concerns include a fear of "freezing" when speaking in front of an audience, or forgetting what one planned to say, or saying "boring things" which the audience will find uninteresting, or "making a fool out of oneself."

6. the belief that others do not respond to them well. But when observed in interactive situations, it becomes apparent that Reticent communicators themselves show little reaction to others, often appearing unexpressive, with little facial muscle movement, little encouragement

of the other person's communication, etc. When asked why they do not respond more affectively, the most frequent response is that they perceive themselves to be actively involved in the interaction and honestly do not realize that they are not "giving off" cues indicative of interest.

7. a feeling that others see them as quiet or shy and thus Reticent communicators feel irrevocably branded as such.

8. difficulty verbally defending a point of view. Often Reticent people tend to "take flight" rather than verbally "fight" when confronted or contradicted in a discussion of a topical/controversial/personal nature. Also, they rarely confront others but, instead, withdraw from the interaction; anger and resentment are expressed passive-aggressively rather than directly.

9. difficulty expressing oneself directly, concisely and in a logical, structured manner.

10. a tendency to perceive that others speak "better" than they. Often Reticent people harbor a pervasive feeling that others are more outgoing and verbally skilled than they and that others are apprehension-free in interpersonal interactions while they alone feel tremendous anxiety.

11. such physiological cues as sweaty palms and forehead, little body animation, little facial animation, minimal eye contact, reduced voice volume, etc. when engaging in interpersonal inter-actions perceived as threatening.

As mentioned above, many of us are uncomfortable or ineffective in certain communicative encounters; but it is the pervasiveness and resulting goal debilitation that differentiates "normal" situational reticence

from clinical Reticence.

Physician Reticence

The physician role of expert technician primarily engaged in diagnosis and prescription is inadequate to a holistic approach to competent patient care. Health is much more comprehensive than the absence of disease or organicity and care is much more comprehensive than application of pharmacological, or surgical "treatment". Gorovitz and McIntyre in their article, "Toward a Theory of Medical Fallibility," (11) emphasize that each human being's body is unique, responds idiosyncratically to its particular environment, and responds idiosyncratically to "standard medical treatment." Therefore, to comprehensively and competently treat a patient, a physician must attend to the "total patient" and his/her unique environment. A person's lifestyle, socio-emotional needs, obligations, responsibilities, self-perceptions, all affect the etiology, nature, course, prognosis, and viable treatment plan for a particular patient and illness. Thus a holistic approach to patient care presupposes physician facility in interpersonal communicative interactions.

However, a Reticent physician would be deficient in some skills imperative to the establishment of such a relationship. First of all, a physician needs to be facilitative and supportive but yet must maintain authority, directing the relationship and treatment of the patient. We have found that first year medical students often report an uncomfortableness "prying" into the psychosocial, sexual, etc. history of patients. When observing themselves on videotape, they sometimes notice themselves verbally and/or nonverbally pulling away

from the patient when the patient begins disclosing personal, intimate information. Because many students have never had experience assuming the role of facilitator/listener/authority figure in a clinical context, their uncomfortableness is certainly understandable and with experience and guidance, should eventually acclimate to and successfully assimilate the various facets of the physician role.

Though comfortableness and interpersonal techniques develop with experience, experience alone may not suffice for the pervasive, deep-seated communication problems characteristic of Reticence. Medical students identified as Reticent more frequently expressed feelings of fear, anxiety, lack of control, avoidance of psychosocial data, etc. in their doctor/patient interactions. Eliciting and discussing highly personal, emotive, intimate concerns in a supportive, open-ended manner involves specific skills and a certain demeanor of openness and comfortableness on the part of the clinician. One can learn to rotely elicit certain pieces of personal history but the reliability, validity and detailedness of such data largely depend on the physician's rapport with the patient. Reticent communicators tend to have difficulty decentering (i.e., accurately perceiving and interpreting the behavior of others and the effects their own verbal/nonverbal behavior may have on others), and thus, as physicians, would be deficient in rapport establishing skills.

Moreover, characteristic of Reticence is a tendency to be highly-structured, sometimes pursuing specific goals with tunnel-like vision, overlooking all that lies outside the tunnel. If one is uncomfortable

interacting with people and tends to be as concise as possible, verbally gleaning only the most basic clinical data, then one may fail to establish rapport with the patient and neglect to elicit certain valuable data not readily offered by the patient. In short, a Reticent physician may tend to be more protocol oriented than patient oriented, rotely adhering to a diagnostic protocol, neglecting to open-ently elicit potentially relevant clinical data. A Reticent physician might ignore or abbreviate verbal aspects of diagnostic interviews, prematurely proceeding or retreating to the "hands-on" format of the physical exam because it provides more structure and alleviates the burden or threat of developing effective skills for verbally interacting with patients as people. Time constraints are often cited as the rationale for such avoidance behaviors; however a little more quality time spent skillfully talking to a patient might uncover information that may later save much time and money in lab tests, exploratory procedures, repeated office visits, evening phone calls, malpractice suits, etc.

Confrontation is another particularly difficult area for Reticent communicators. As physicians, if confronted by a hostile or difficult patient (regardless of whether the patient's hostility is warranted) they may not have the communication skills necessary to respond constructively, neither ignoring nor counter-attacking the patient. When confronted, Reticent individuals tend to overly internalize the threat and thus over-react (often passively-aggressively) without constructively dealing with the patient's overt and covert needs in expressing the hostility.

Peticent physicians are also less likely to routinely provide "patient education." Effective patient education sometimes involves

sensitivity to subtle patient needs as well as increased verbal interaction with the patient. The physician must be sensitive to the patient's nonverbal as well as verbal cues and be prepared to respond to these cues while creating a comfortable and open atmosphere; such physician behavior necessitates interpersonal skill and, again, an ability to decenter (i.e. see the world from the patient's perspective, needs, fears, values, obligations, etc.).

For example, a Reticent gynecologist may not carefully explain the various methods of birth control, detailing the procedures, risks, advantages, side effects, etc. Instead she/he may suggest one method or quickly mention alternatives neglecting to elicit or deal with the particular patient's feelings, fears, personal needs, uncertainties, etc. Eliciting the patient's personal needs and uncertainties involves interpersonal skill and sensitivity as well as comfortableness in talking about intimate behavior and these are areas in which Reticent people have most difficulty.

Similarly, in such holistic specialties as Family Practice, the physician needs to be sensitive to and skilled in eliciting psychosocial data as well as physical data per se that may be affecting the patient's well being. Again, a Reticent physician may fail to elicit or tend to avoid approaching personal data, preferring to keep verbal interactions to a minimum and the talk as clinical as possible. Also she/he may shy away from confronting one family member about behaviors that may be affecting the welfare of another family member.

Pilot Reticence Program

A pilot Reticence Program for first year medical students was initiated at Southern Illinois University Medical School Carbondale in Fall, 1976. Enrollment was initially limited to 10% of the first year class¹ on a "first come" basis. Since Southern Illinois University Medical School operates on a modularized, competency based, ungraded, self-paced system, the Reticence Program could not assume the format of a formal course in which students enroll for a prescribed length of time, receiving a grade and credit hours at its completion. Instead, the Reticence Program was instituted on a voluntary basis as an additional activity in an already exceptionally time-demanding curriculum. The students electing to participate received no credit, grade, or recognition of any sort for assuming this additional responsibility.

Student Selection

Several selection devices including a variety of paper and pencil standardized "anxiety scale" tests have previously been experimentally employed in the natal Reticence Program at the Pennsylvania State University.² The paper and pencil "anxiety indicators" were found to be unsatisfactory selection devices. Instead, Reticence selections are made on the basis of students' self reports during an interview with the Reticence Program director.

At an orientation session held shortly after the students begin their first year of medical school in June, the students are introduced to the Reticence Program.³ Students are provided a verbal description of the nature and goals of the program and are then given

a handout listing "Reticence Indicator Questions," i.e., a list of fifteen items referring to common reticent behaviors and feelings. For example, "Do you feel you have difficulty holding up your end of a group discussion or dyadic conversation?" "Do you avoid asking questions in class, even when you have read the material and still do not understand it?" "Do you feel a great deal of anxiety about speaking in front of an audience of 10 people or more?" "Do you tend to avoid talking to faculty or other authority figures?" etc. Those students who feel that the indicator questions characterize many of their own communicative behaviors and seriously want to invest their time and energy trying to alter some of their present behaviors are invited to an informal screening interview with the Reticence Program director. Student and instructor then reach a mutual agreement as to the utility of the program for the particular student.

It is important that enrollment be voluntary. The instructional format and strategies are designed to assist those dissatisfied with and willing to change certain communication behaviors; the program is not directed at overtly persuading people to alter their behaviors. Paper and pencil standardized selection procedures are inadequate because they violate the voluntary stipulation; they sometimes produce people who are hostile or indifferent to changing their behaviors and overlook others who may not fall below the test's criterion score but who eagerly want to work on altering their communicative skills.

Reticence Training

We have found that approaching Reticence as a perception and learning problem has proven the most clinically useful. Evidence indicates that most Reticent communicators: 1) do not know what behaviors are most

appropriate and effective in particular situations; they do not know the rules and moves of the interpersonal/academic situations in which they find themselves, (e.g., a person may not know how to initiate a social conversation: That is, the person may not know how to verbally/nonverbally approach someone, what to say, what to do, how to end it, etc.) 2) know what behaviors are appropriate and desirable but because of their egocentric perception of the situation feel too much inhibition to take the interpersonal risks involved in performing the behavior, (e.g., a person knows how and when to raise his/her hand in class and ask a question but fears that the question will "sound stupid" and that she/he will be the center of attention). Thus in the Reticence Program, we focus on increasing the students' repertoire of behaviors, teaching heuristics for deciding what types of behaviors are most effective in which situations, what the possible outcomes and effects of these behaviors may be, what alternatives are available, and how to more accurately and flexibly interpret and adapt to other's communicative cues.

Goal Analysis

Pedagogically, our approach to Reticence involves a modified goal analysis format premised on Robert Mager's Goal Analysis (12) and adapted to the specific needs of Reticent communicators. Mager suggests that if one is to work on altering behaviors one must have a clear, concretely specifiable image of what the desired communicative behaviors will look like. We have found that Reticent medical students' communicative goals are often unrealistic or diffuse and behaviorally unspecifiable; e.g., "I want to interact with patients more successfully," "I want to be a

fluent, more dynamic speaker," "I want to feel more comfortable when talking to others, especially faculty," "I want to be a more confident, self-assured person." Mager refers to such diffuse objectives and goals as "fuzzies" and says that they often lead to frustration and feelings of failure because they do not provide definitive behavioral parameters to gauge communicative success. Characteristically, Reticent people tend to negatively evaluate themselves and their accomplishments, often without warrant, blaming past experience or situational or environmental factors for their perceived failures. Goal analysis forces one to clarify communicative goals, (i.e., define them in terms of specific overt behaviors, rather than feelings or results) and thus it provides visible criteria to gauge success. Further, goal analysis teaches one to identify and clarify specific overt behaviors to be accomplished and then Reticence class instruction works on developing those skills and perspectives that will lead to accomplishment of the specified objectives.

In summary, the goal analysis procedures of Reticence training involve leading students through the following steps:

1. stating an end goal, (e.g., "I want to interact with authority figures more effectively and comfortably").
2. listing the specific, overt actions or performances which if achieved would result in the student agreeing that the goal is achieved.
3. specifying the situation (who the student will be speaking to, about what, where,, when, how long, for what purpose, etc.). These must be specified in advance.
4. specifying criteria by which the student can gauge success.

5. rehearsing the situation in a class context, receiving feedback from others who may have had similar fears, experiences, encounters.

6. carrying out the goal.

7. after the goal is performed, talking about which of the criteria of success were met and then talking about alternative actions or ways of perceiving and interpreting the situation if the person did not meet most of his/her criteria for success.

During the first week of the Interpersonal Skills Workshop (Reticence class) participants write a Self-as-Communicator paper indicating those goals that are most important to them. The students are then divided into small groups (3-5 people) based on similarity of goals specified. Groups serve a preparation, feedback, and rehearsal function. Each class period students work in their respective groups, analyzing rehearsing, or role playing their goal situation(s) or working on exercises designed by the instructor to prepare them for accomplishing each of their specific goals. The instructor's time is divided between groups, monitoring exercises, providing feedback, role playing, etc. Sometimes groups are combined or shifted; for instance, if someone wants to practice presenting a speech to ten people, two groups are combined to comprise the rehearsal audience. Meanwhile students acting as audience might be fulfilling goals such as asking more questions in class, participating more actively in class discussions, etc. Completion dates are set for each goal accomplishment and then new goals are set and often new groups are formed accordingly. Thus emphasis is placed on approaching long standing goals with new behaviors and new perceptions of self and other.

Program Assessment

With only one pilot run, it is too early to provide any definitive assessment as to the success of Reticence training in a medical school context. However, there are a few indicators that the program is achieving its goals. First, student self-reports indicate that those who participated were all quite satisfied with the program. All felt that they had achieved their individual goals and were pleased with the results.

Secondly, all first year medical students at Southern Illinois University participate in a videotaped diagnostic interviewing program. (The interviewing portion of the program runs from February through May). Three videotaped interviews are faculty reviewed and evaluated. Of the students who participated in the Interpersonal Skills Workshop beginning in September, all were later rated as average to above average by faculty in the interviewing program. On the other hand, approximately 8% of the first year students were designated by faculty evaluators as having communication problems warranting special attention. None of the students who participated in the Interpersonal Skills Workshop were among the students in this group. Furthermore, of the students designated by faculty as having communication problems, half expressed an earlier interest in participating in the Interpersonal Skills Workshop before faculty evaluators suggested that they seek such help. However their expressed interest in the program came several months after the Workshop had begun and logistic problems prevented their inclusion.

The Interpersonal Skills Workshop will be offered again Fall, 1977 for the incoming class of medical students at SIU and enrollment size will not be sharply limited as it was for the pilot program. Also

the program will be expanded to include groups of students who would like to work on specific types of problems, (e.g., women students concerned with altering role identity behaviors in their interactions with male faculty members and male patients, etc.).

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Footnotes

¹Staffing, scheduling, and logistic concerns necessitated limiting the size of the pilot program. Over 15% of the first year students expressed interest but only 10% were formally included while others were provided with individual help.

²The Penn State program is designed to accommodate undergraduate students from all academic majors; it is not geared to medical or premedical students.

³It is formally referred to as the Interpersonal Skills Workshop; The students are not introduced to the term "reticence" per se.